

Medical Documentation

Guideline: Information reflecting the medical plan of care as well as other pertinent medical information should be documented in the individual's record in an accurate, timely, and legible manner.

DEFINITIONS:

Do-Not-Resuscitate (DNR) Order: A written order by the responsible physician to suspend the otherwise automatic initiation of cardiopulmonary resuscitation. The DNR order does not preclude: maintaining an adequate airway by suctioning the mouth, nose, pharynx and trachea or the Heimlich maneuver, and other indicated medical and surgical therapy including but not limited to antibiotics, nasogastric or other type of tube feedings, parenteral hydration and feeding, blood products, and cardio-active substances.¹

Individual's record: A permanent legal document that provides comprehensive information about the individual's health care status.

Primary care prescribers: Physicians, nurse practitioners, and physician's assistants who provide primary care services and are authorized to prescribe medications and treatments for people on their assigned caseloads.

Medical progress notes: The section of the individual's record where primary care prescribers document their findings and provide rationale for treatment plans.

Nutritional Management Committee: A team of professionals with knowledge of the causes and treatment of dysphagia that should meet to discuss issues related to dysphagia and associated disorders and make recommendations as appropriate.

Patient capable of consenting to DNR: An adult who has the ability to communicate and understand information and has the ability to reason and deliberate about the choices involved.¹

Patient incapable of consenting to DNR: An adult who is unable to appreciate the nature and implications of his/her condition, or to make reasoned decisions concerning his/her care or to communicate decisions concerning his/her care in an unambiguous manner. This status should be verified by clinical assessment of the patient's mental and emotional status by two physicians.¹

RATIONALE:⁴

1. Documentation in the individual's record facilitates communication among professionals from different disciplines and on different shifts. It provides information so that health care providers can deliver care in a coordinated manner.
2. Information in the individual's record is a source of data for quality assurance and peer review programs.
3. Reimbursement from third-party payers (i.e., Medicaid, Medicare) is based in part on the quality and timeliness of medical care reflected in the individual's record.
4. The individual's record serves as a legal document that may be entered into courtroom proceedings as a record of care the person received.

EXPECTED OUTCOMES:

Assessment

Documentation should reflect that medical assessment occurs on a timely and regular basis.

1. An admission history and physical should be completed in accordance with the regulatory standards for the facility.
 - a. Intermediate Care Facilities for the Mentally Retarded (**ICFs/MR**): Within 24 hours of admission but no later than 48 hours after the person is admitted.
 - b. Community Residential Care Facility (**CRCF**): Within 30 days prior to admission.
 - c. Community Training Homes (**CTH I** and **CTH II**) and Supervised Living Programs (**SLP**): Within one year prior to admission.
2. A comprehensive annual assessment of the person's medical status should be completed and documented. Documentation should include:
 - a. results of the physical examination;
 - b. pertinent changes in health status that occurred in the last year;
 - c. significant illnesses and/or diagnostic tests occurring in the last year; and
 - d. status of all major medical problems (e.g., all items on the Major Problem List)
3. Results of physical examinations should be documented or dictated the day the examination is performed.
4. Dates and signatures should be included on all progress notes the day they are written or, if dictated, within 2 working days after being transcribed.

Diagnosis

All diagnoses should be properly documented in the individual's record. In Regional Centers, the Major Problem List should be complete and up to date.

Planning

Documentation should reflect that a medical plan of care is developed based on medical assessment and diagnosis.

1. There will be a medical plan of care for people needing 24 hour nursing care. The primary care prescriber should participate in the development of the plan.⁵ The primary care prescriber's signature will indicate agreement with the plan that has been developed.
2. Self administration of medication programs should be implemented only upon the recommendation of the interdisciplinary team and if a medical order exists.^{6,7}
3. The primary care prescriber should consider recommendations from the appropriate professional staff and/or the Nutritional Management Committee when prescribing modified and special diets.

Implementation

Documentation should reflect that the plan developed to meet health needs/problems is being implemented.

1. The S-O-A-P format is the recommended style for medical documentation.
 - a. **S**ubjective: Includes historical information relevant to the person's health condition or complaint. This information is often extracted from the individual's health record.
 - b. **O**bjective: Includes results of physical examination, diagnostic procedures, including relevant laboratory and diagnostic imaging results.

Implementation cont'd

- c. **A**ssessment: Includes evaluation of subjective and objective data and clinical diagnosis
- d. **P**lan: Includes the proposed treatment plan. If treatment interventions are ongoing, a

summary of results is documented in this section.⁸

2. A progress note should be written that gives the rationale for laboratory work and x-rays ordered.
3. The primary care prescriber should review the results of laboratory work, x-rays, and consultations. The primary care prescriber should date and initial the reports to verify that review has been completed.
4. A progress note should be written regarding medical treatment rendered and the person's response to the treatment.
5. If recommendations made by consultants are not implemented, there should be documentation in the medical progress notes outlining the rationale of why recommendations were not followed.

Evaluation

Documentation should reflect that outcomes of medical interventions are carefully evaluated.

1. Documentation in the medical progress notes should reflect review of the person's overall health status at least every 90 days in ICFs/MR.
2. Regular and timely entries must be made in the medical progress notes reflecting ongoing medical review and interventions for acute health problems. Documentation should include the status of significant medical problems until problems are resolved.
3. Documentation in the medical progress notes should reflect review of pertinent x-ray and laboratory results.
4. Rationale for all changes in medications should be documented in the medical progress notes.
5. The medical progress notes should include information about adverse drug reactions, what treatment was rendered, and person's response to treatment.
6. In ICFs/MR, the review of the quarterly pharmacy report⁹ and reports from other health related disciplines should be verified by the primary care prescriber dating and initialing the report at the time of review.
7. When irregularities in drug regimens are noted in the ICFs/MR quarterly pharmacy report⁵, the primary care prescriber should make changes in the medication regime or provide rationale for continuing the treatment. Documentation of the action taken or rationale should be included in the medical progress notes.
8. If a person living in an ICF/MR is transferred to another unit or facility, the transferring primary care prescriber or designee should write a summary note that includes the significant health history and current health status.
9. At the time of discharge, a summary of medical history and a post-discharge medical plan should accompany the person to the new residence. A copy should also be sent to the new health care provider.
10. **Documentation for Do-Not-Resuscitate (DNR) decisions.** If it is determined that a person will not be resuscitated if he/she suffers cardiac or respiratory arrest, all forms and orders required to initiate and renew "*Do Not Resuscitate*" status will be completed.¹⁰

Documentation for Do-Not-Resuscitate (DNR) decisions cont'd

- a. The 'Do-Not-Resuscitate' (DNR) order is the responsibility of the physician who is responsible for the person's care. While being cared for in a DDSN facility, only Departmental physicians attending the patient or a consulting physician may write a DNR order for consumers.
 - b. All DNR orders must be written, dated and signed. No verbal or partial orders may be given.
 - c. DNR orders expire after 30 days and may be reordered by the physician as appropriate.
 - d. The DNR order must be documented and explained in the medical progress notes. The progress notes will also include information on the person's ability to give consent.
 - e. The "Emergency Medical Services Do Not Resuscitate Order" (see attachment) form is to be filled out and filed in the individual's record.
 - f. The responsible physician will review the DNR order and seek renewal of consent at the time of the annual Single Plan or sooner if needed.
 - g. All DNR orders will be reviewed by the local ethics committee for consistency with the procedural requirements of Departmental Directive 603-07-DD.
11. Patients who have a DNR status and are to be transported by EMS or ambulance carrier must have a completed "Emergency Medical Services Do Not Resuscitate Order" form (see attachment) accompany them to the receiving facility. The EMS or ambulance crew must be aware that the DNR status is in effect and that the attached form is included in the transfer records.¹¹

Guidance for Do-Not-Resuscitate Decisions

(Please see Departmental Directive 603-07-DD for the complete Do-Not-Resuscitate Operational Guideline that applies to DDSN Regional Center Patients)¹²

Do-Not-Resuscitate (DNR) orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient, including nutrition, hydration, palliative care, pain relief, or other ongoing treatments.

Resuscitation decisions for patients capable to give consent:

1. The voluntary choice of an informed patient able to give consent will determine whether cardiopulmonary resuscitation will be undertaken. If an adult is capable of giving consent, his or her concurrence should be obtained with written documentation, when possible.
 - a. A patient who is able to give consent may request a Do-Not-Resuscitate order at any time. This decision should be reached consensually by the responsible physician and the patient, with care taken to ensure that the patient has an accurate understanding of such a decision. For a patient capable of giving consent, the consent of the next-of-kin or surrogate is not required.
 - b. The physician should document the mental condition of the patient in reference to the informed decision that resulted in the Do-Not-Resuscitate order being written. This information should be signed and dated by the physician.
 - c. The patient has the right to have a Do-Not-Resuscitate order withdrawn upon request.

Resuscitation decisions for patients capable to give consent cont'd:

- d. If a patient later becomes unable to give consent, his/her decision made while capable of giving consent shall be respected.

2. The family may be informed of such decisions, unless the patient specifically requests that they not be so informed. When contacting the family, the facility director or his designee should inform the family of the patient's wishes and the option they have for pursuing judicial relief.

Resuscitation decisions for patients not capable to give consent:

1. The voluntary choice of a surrogate decision-maker of a patient incapable of giving consent will determine whether cardiopulmonary resuscitation will be undertaken. The patient should be involved, however, in decisions about care and treatment to the extent of his/her capabilities.
2. If the person is not capable of consenting, the medical progress notes should indicate the discussion with and written concurrence of the surrogate. The written concurrence of the surrogate must include the date, time, and signature of the surrogate and name of the physician with whom the patient's condition was discussed. The written documents are to be filed in the medical progress notes section of the individual's record.
3. If it is determined by independent evaluations by two physicians that an adult is not capable of giving consent, the progress notes should include the following information:¹³
 - a. the Non-Emergency Health Care Consent Form (pink form) has been completed,
 - b. the situation has been thoroughly discussed with the surrogate decision-maker,
 - c. the surrogate decision maker is in agreement with the DNR order, and
 - d. written concurrence of the surrogate has been obtained. The written concurrence of the surrogate must include date, time, and signature of the surrogate, and the name of the physician with whom the person's condition was discussed.
4. The completed original of the Non-Emergency Health Care Consent Form is filed in the individual's medical record.

Resuscitation Decisions for Minors

1. For children less than 18 years of age who are capable of giving consent, their preferences will be respected if they choose to be resuscitated regardless of their parent's or family's wishes.¹⁴
2. When a child less than 18 years of age chooses not to be resuscitated, the wishes of his/her parents will be respected.¹⁵
3. When the patient is a minor, decisions regarding his/her health care must be made by the persons in the following order of priority:
 - a. legal guardian with court order,
 - b. parent,
 - c. grandparent or adult sibling,
 - d. other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the child,
 - e. other person who reasonably is believed by the health care professional to have a close relationship with the child, or
 - f. authorized designee of the Department, usually the Facility Administrator or Executive Director of the DSN Board.^{16,17}

REFERENCES

1. DDSN Departmental Directive 603-07-DD "Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>

2. DDSN Departmental Directive 603-07-DD “Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>
3. DDSN Departmental Directive 603-07-DD “Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>
4. Scott, R. W. (2006). Legal Aspects of Documenting Patient Care for Rehabilitation Professionals (3rd ed.). Sudbury, MA: Jones and Bartlett Publishers.
5. ICF/MR Interpretive Guidelines - Tag number W320.
Available: <http://www.cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp>
6. SC DHEC Regulation 61-13. Standards for Licensing Habilitation Centers for the Mentally Retarded or Persons with Related Conditions. Section I. (4) (f).
Available: <http://www.scdhec.gov/hr/pdfs/licen/licregs/r61-13.pdf>
7. SC DHEC Regulation 61-84. Standards for Licensing Community Residential Care Facilities. Section 1202.
Available: <http://www.scdhec.gov/hr/pdfs/licen/licregs/r61-84.pdf>
8. Scott, R. W. (2006). Legal Aspects of Documenting Patient Care for Rehabilitation Professionals (3rd ed.). Sudbury, MA: Jones and Bartlett Publishers.
9. ICF/MR Interpretative Guidelines - Tag numbers W362, W363, and W364.
10. DDSN Departmental Directive 603-07-DD “Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>
11. SC DHEC regulation 61-7 Emergency Medical Services. Section 1202 A.
Available: <http://www.scdhec.gov/hr/pdfs/licen/licregs/r61-7.pdf>
12. DDSN Departmental Directive 603-07-DD “Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>

13. DDSN Departmental Directive 535-07-DD “Obtaining Consent for Minors and Adults” (April 15, 2003 revision).
Available: <http://web.ddsn.gov/pronet/policies/535-07-PD.htm>
14. DDSN Departmental Directive 603-07-DD “Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>
15. DDSN Departmental Directive 603-07-DD “Do Not Resuscitate (DNR) Operational Guideline (February 5, 2003 revision)
Available: <http://web.ddsn.gov/pronet/policies/603-07-PD.htm>
16. DDSN Departmental Directive 535-07-DD “Obtaining Consent for Minors and Adults” (April 15, 2003 revision).
Available: <http://web.ddsn.gov/pronet/policies/535-07-PD.htm>
17. S.C. Code Ann. §44-26-60 and §44-66-10 (Supp. 1999).